

Disease Specific Chronic Care Management for the Underserved Population

More than 30 million Americans are currently living with diabetes.¹ Each year, an additional 1.5 million are newly diagnosed.² Diabetes has a major impact on people who live with the disease, their family members, and society as a whole. Not all people living with diabetes have equal access to care or the necessary resources to successfully self-manage their disease. As a result, hospitals across the nation have seen an influx of diabetic cases flow through their emergency departments. The costs associated with diabetic hospitalizations can easily be reduced and/or avoided with the implementation of comprehensive case management for those with complex health and social needs.

Beginning in 2011, Jefferson Health New Jersey embarked on the Delivery System Reform Incentive Payment Program (DSRIP) with the New Jersey Department of Health and Centers for Medicare & Medicaid Services. Our DSRIP program focuses on the care and treatment of patients 18 years and older, who are residents of New Jersey, living with diabetes and/or hypertension, insured by Medicaid, Managed Medicaid and Charity Care.

The goals of Jefferson Health New Jersey DSRIP program are: to increase patient access to primary and specialty care; improve care coordination between hospital and outpatient settings; improve patient self-care management; reduce hospital admissions relating to complications of diabetes and hypertension; reduce unnecessary Emergency Department (ED) visits; increase preventive diabetes

and hypertension health screenings; promote overall wellness; and leverage technology to facilitate patient tracking and communication of clinical data. The overarching goal of our project is to address the critical gap between clinical care and community services in the current health care delivery system.

Currently, the project has enrolled more than 4,000 patients, who are provided medical services from over 800 physicians. Jefferson Health New Jersey has implemented relationship-building as the primary method to engage patients in their health care, with such techniques as motivational interviewing and therapeutic communication, as well as addressing health-related social needs through enhanced clinical-community linkages.

Many of our patients have complicated social needs that must be addressed in conjunction with their medical needs. Unmet health-related social needs, such as food insecurity and inadequate or unstable housing, may reduce an individual's ability to manage their medical conditions, increase health care costs, and lead to avoidable health care utilization.

Evidence-based health coaching approaches were designed and are utilized to support effectiveness in patient engagement and care. This is an innovative approach that our DSRIP team has embraced to engage patients. It puts the focus solely on the patient, which is different from the traditional medical model in which health care professionals who "know best" define the agenda, terms, and the goals of

care. Through this practice, the team has developed and refined their Motivational Intervention (MI) techniques that help patients work through ambivalence with change-talk and goal setting.

In addition to linking patients to appropriate social services, our master's level social workers employ cognitive behavioral therapy as a technique to address issues with treatment adherence and psychosocial barriers to overall health.

Our nurse navigators work with patients to provide clinical education in order to better understand their chronic medical conditions, symptoms, medications and actions they can take to support their health.

As a result of the team's continuous efforts in patient engagement, care coordination/navigation, and education, the team has had many successes within the last year.

The DSRIP team has seen a 17% overall reduction in ED utilization and hospitalization of patients and a 15% reduction in hospital admissions for uncontrolled diabetes. In addition there has been an 11% reduction in hospital admissions for short-term complications due to diabetes and a 23% reduction in hospital admissions for uncontrolled hypertension. Jefferson Health New Jersey's DSRIP project has resulted in a significant reduction in health care spending, through reduced hospital costs and reduced governmental payments, aggregating approximately \$3.3M.

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Unlike other population health case management initiatives, DSRIP provides a comprehensive, collaborative, patient centered approach that educates and empowers patient to enact the changes they need to improve their overall health. This initiative provides a strong return on investment that can be reinvested into health promotion and improving quality outcomes across the Jefferson Health NJ community. Chronic care management programs will

become essential revenue sources to hospital systems as financial incentives for better quality outcomes become standard with the adoption of MACRA. Our DSRIP model has shown great success in managing care for those underserved patients with diabetes and hypertension. We believe our model will easily translate to additional disease states and can be used for future Jefferson Health chronic Case Management applications such as COPD, Congestive Heart Failure, and Asthma.

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